

## 1. HIV Prevention Community Planning

*See Letter of Concurrence in Attachment 1*

**Goal One – Community planning supports broad-based community participation in HIV prevention planning.**

**Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.**

### Recruiting New Members:

In accordance with the bylaws, the Membership Committee is comprised of five CPG members. The Executive Committee appoints the Chair of the Committee, and the CPG elects the remaining four members. Currently, the Committee consists of one (1) African American female, one (1) African American male, one (1) White female and two (2) white males, one of whom is HIV positive. The Committee is responsible for screening the applications, interviewing applicants, and presenting the list of new members to the CPG Co-Chairs, who review the selection process for adherence to the procedure, and then forward the list of selected applicants to the CPG for approval.

Each year the Membership Committee conducts a survey to determine how many members would like to continue to serve on the CPG. Members are retained if they express a desire to remain active; if they want to discontinue their membership, members are asked to complete an exit survey. From the list of returning members, membership gaps are determined. The Membership Committee and CPG members are encouraged to be proactive in soliciting candidates for membership that are in alignment with the gaps and *CDC Guidance, Guiding Principles for HIV Prevention Community Planning, #5*. The By-Laws and Policies and Procedures instruct the CPG and DHEC to use a variety of methods to publicize the recruitment and nomination process including: mailings to newsletter lists, churches, organizations, housing projects, minority and neighborhood newspaper ads, and personal contacts. The CPG application is also available on the DHEC STD/HIV Division website.

Nominations for membership are solicited through the open process mentioned above and candidates are selected, based on criteria that have been established by the health department and the community planning group. An individual can self-nominate or nominate others by completing an application and submitting it to the CPG administrator. The applications provide information about the knowledge, experience, expertise, and personal and organizational affiliations of the nominee. The goal is to obtain more applications than vacancies.

In 2003, the Membership Committee evaluated the practicability of continuing to accept new members as vacancies occurred and conducting new member orientation on an ongoing basis. The recommendation made to the Executive Committee was to replace the former practice mentioned above with conducting new membership intake and new member orientation twice annually beginning in 2004.

**Objective B: Ensure that the CPG(s) membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.**

CDC invited the South Carolina HIV Prevention Community Planning Group to pilot the *Community Planning Membership Survey*. Sixteen (16) of twenty-one (21) CPG members completed the survey on June 16, 2003. Next year, the CPG will strive to have full participation filling out the membership survey. The assessment consisted of two parts. Part I asked about various characteristics of the CPG and some demographic information about the members and the role they played as a CPG member; and Part II asked members opinions about whether the objectives of community planning occurred in your CPG during the most recent year of planning. This instrument was designed to assist CDC and health departments in assessing the implementation of HIV prevention community planning. The results of the survey are captured in the *HIV Prevention Community Planning Membership Survey Report* (Attachment 2) and the *South Carolina HIV Prevention Community Planning Group Membership Worksheet* below.

### South Carolina HIV Prevention Community Planning Group Worksheet

<b>CDC GUIDANCE</b>  Representation of the community planning group includes:  <b>Persons who reflect the characteristics of the current and projected epidemic in that jurisdiction (as documented by the epidemiologic profile) in terms of ...</b>	<b>SC EPIDEMIOLOGIC PROFILE</b>	<b>ACTUAL MEMBERSHIP As of June 16, 2003 (N=16)</b>	<b>MEMBERSHIP GAPS</b>
<b>Age</b>	No. (%) of Total Persons Living with HIV/AIDS, 2001  < 19 = 683 (5%) 20-24 = 1,700 (13%) 25-29 = 2,348 (19%) 30-49 = 7,017 (56%) 50+ = 844 (7%)	No. (%)  <19 = 0 20-24 = 1 (6%) 25-29 = 3 (19%) 30-49 = 8 (50%) 50+ = 4 (25%)	Increase representation and/or participation of youth (<=19 years of age) and young adult (20-24 years of age)
<b>Gender/Gender Identity</b>	No. (%) of Total Estimated Living with HIV/AIDS, 2002  Male = 8,777 (70%) Female = 3,803 (30%) (No data available for transgender population)	No. (%)  Male = 9 (56%) Female = 7 (43%) Transgender = 0 Unknown = 0	Increase representation of males and transgenders
<b>Race/Ethnicity</b>	No. (%) of Total Persons Living with HIV/AIDS, 2002  Black or African American (Not Hispanic) = 9,193 (73%) White or Caucasian (Not Hispanic) = 3,138 (25%)	No. (%)  Black or African American (Not Hispanic) = 11 (69%) White or Caucasian (Not Hispanic) = 4 (25%) Hispanic or Latino = 1 (6%)	Increase representation of African Americans, Hispanic/Latino, Asian /Pacific Islanders, Native Americans/Alaskan Natives

	Hispanic or Latino = 203 (2%)  Note: 3% of new cases reported in 2002 were Hispanic	Unknown = 1 (6%)	
<b>Sexual Orientation</b>	Epidemiologic profile does not reflect this information	No. (%)  Heterosexual = 10 (63%) Gay Men = 6 (38%) Lesbian = 0 Bisexual = 0	INCREASE REPRESENTATION OF SELF-IDENTIFIED GAY MEN, LESBIANS, AND BISEXUAL MEN
<b>Socioeconomic Status</b>	<\$10,000 = 39% >\$10,000 = 59%	<i>Community Planning Membership Survey</i> does not request this information	
<b>Geographic and Metropolitan Statistical Area (MSA) – Size Distribution (Urban and Rural Residence)</b>	About half (54%) of persons living with HIV live in larger urban MSA's (Columbia, Charleston, Greenville, Spartanburg, Anderson, and York counties. But, 46% live in all other counties—in particular Sumter, Florence, Orangeburg, Horry, Beaufort.  Among new cases in 2002, 51% were in larger urban MSA's, 49% rural.	No. (%)  Urban Metropolitan Area = 2 (13%) Urban Non-Metropolitan Area = 8 (50%) Rural Area = 6 (38%)	Increase representation of persons living in urban metropolitan statistical areas specifically Charleston, Greenville, Spartanburg, Anderson, and York counties
<u><b>Serostatus</b></u>	Epidemiologic profile does not reflect this information	No. (%)  Living with HIV/AIDS = 3 (19%) Not Living with HIV/AIDS = 12 (75%) Don't Know = 1 (6%)	Increase representation of HIV positive persons
<b>Risk for HIV Infection</b>	Proportion of Persons Living with HIV/AIDS by Risk Exposure, 2002  MSM = 4,110 (33%) Heterosexual = 3,403 (27%) IDU = 1,509 (12%) Other (blood transfusions, hemophilia, perinatal transmission) = 253 (2%) No Risk Identified = 3,308 (26%)  From 1995-2001, the number of persons living with HIV/AIDS increased by 63%.	No. (%)  MSM = 5 (31%) MSM/IDU = 1 (6%) IDU = 1 (6%) Heterosexual = 5 (31%) Mother with or at risk for HIV infection = 0 General Public = 0 Unknown = 0	Increase representation of IDU and mother with or at risk for HIV infection
<b>State and local health department HIV Prevention and STD treatment staff ; staff of state and local education agencies; and staff of other relevant governmental agencies (e.g., substance abuse, mental health, corrections)</b>	Epidemiologic profile does not reflect this information	No. (%)  State Health Department: HIV/AIDS = 2 State Health Department: STD = 1 Substance Abuse = 1 Mental Health = 1 Department of Corrections = 1 Department of Education = 1	Increase representation of Department of Social Services, Department of Juvenile Justice, Department of Disability and Special Needs, etc.

		Academic Institution = 1	
<b>Experts in epidemiology, behavioral and social sciences, program evaluation, and health planning</b>	Epidemiologic profile does not reflect this information	No. (%) Epidemiologist = 0 Behavioral or Social Scientist = 3 Evaluation Researcher = 0 Intervention Specialist = 3 Health Planner = 2 Community Representatives = 7 Directly Funded CDC CBO = 2 Other = 1 (6%)	Increase representation of experts in epidemiology and evaluation research  CPG has access to and utilizes DHEC surveillance, evaluation and epidemiology staff as needed  Request CDC to define representation categories on the membership grid
<b>Representatives of key non-governmental and governmental organizations providing HIV prevention and related services (e.g., STD, TB, substance abuse prevention and treatment, mental health services, homeless shelters, prisons/corrections, HIV care and social services, education agencies) to persons with or at risk for HIV infection</b>	Epidemiologic profile does not reflect this information	No. (%) HIV Prevention Collaborations = 9 AIDS Service Organizations = 2	Increase representation of youth serving organizations such as teen pregnancy prevention councils, homeless shelters, county jails, Hepatitis C Coalition, Syphilis Elimination Coalition, etc.
<b>Representatives of key non governmental organizations relevant to, but who may not necessarily provide, HIV prevention services (e.g., representatives of business, labor, and faith communities)</b>	Epidemiologic profile does not reflect this information	Faith Community = 1 Minority Board CBO = 6 Non-minority Board CBO = 3	Increase representation of business/labor, faith communities, etc.

The CPG used current and projected epidemic, as documented in the prior year's epidemiologic profile, and persons living with HIV/AIDS to determine populations most at risk for HIV infection. The above worksheet demonstrates that the CPG membership includes:

- Representatives from the affected community in terms of race/ethnicity, gender/gender identity, sexual orientation, and geographic distribution;
- Professional expertise in behavioral/social science, epidemiology, evaluation and service provision;
- Key government agencies; and
- Key governmental and non-governmental agencies with expertise in factors and issues relative to HIV prevention.

The Executive Committee has directed the Membership Committee to develop a 2004 action plan that will address the gaps outlined in column 4 of the worksheet and develop and implement strategies for filling them.

**Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.**

Inclusion:

There is one statewide community planning group in South Carolina. As mandated by the Centers for Disease Control and Prevention (CDC), the South Carolina Department of Health and Environmental Control (DHEC), Division of STD/HIV, established the South Carolina HIV Prevention Community Planning Group (CPG) in 1995. The maintenance of the CPG is also the responsibility of the health department. The CPG is governed by three documents *HIV Prevention Community Planning Guidance*, Policies and Procedures, and Bylaws which include the decision making process and conflict of interest rules. Currently, the CPG is in the process of amending their bylaws and revising the policies and procedures.

The group traditionally meets on the third Monday of each month, provided it is not a holiday, from 9:00 a.m. – 3:00 p.m. at a local hotel in Columbia. Even though, the CPG meetings are opened to the public, and attempt to gather input from the community informally through “good of the order”. The CPG will formally institute a time for public comment at each meeting in 2004.

To increase retention, great efforts are taken to accommodate or facilitate members who face challenging barriers to their continued participation in the CPG. In accordance with state regulations, CPG members who travel at least 100 miles roundtrip from their home and/or office to the meeting site may apply for lodging and mileage reimbursement. The policies and procedures also allow stipends for non-state employees and meal reimbursement for overnight stays.

Additionally, input is obtained from representatives of marginalized groups, who would be hard to recruit and/or retain as CPG members, in order to assure that their views, perspectives, and needs are included in the community planning process. Below are examples of methods used to gather information from outside group membership.

- Eleven local HIV prevention collaborations include several partners such as AIDS service organizations, alcohol and drug abuse facilities, churches, schools, youth groups, mental health agencies, local health departments, etc. The lead organization, or contractor, receives the funds on behalf of the group, but the Collaborative members partner together to develop and implement local plans using the population priorities and intervention identified in the state comprehensive HIV prevention plan written by the CPG.
- The CPG Committee membership is open to any individual interested in preventing the spread of HIV/AIDS in South Carolina. There are five committees that community persons and SC HIV Prevention Collaboration can serve. They are 1) Needs Assessment Committee, 2) Behavioral and Social Science Committee, 3) Technical Assistance and Training Committee, 4) Public Relations and Marketing Committee, and 5) Youth Committee.

- The CPG convened two ad hoc committees composed of CPG members, collaborations, health departments, and consumers: 1) Edisto HIV Prevention Regional Forum Planning Committee, and 2) SC HIV Prevention Community Planning Leadership Summit.

The Edisto HIV Prevention Regional Forum is scheduled for October 24, 2003 at Richard Carroll Elementary School in Bamberg County. The CPG works in concert with the local health department, collaboration and community advocates to plan the forum. This body was referred to as the Planning Committee, and their purpose was to assist with the logistics such as who should be invited, where should the forum be held, when is the best date and time to have the forum, etc. Additionally, the Planning Committee helps develop the program format and advertises the event. They tell us about the HIV educational needs of their community, and a program is designed based on the identified informational needs. Time for public comment is allowed at the conclusion of the program.

The South Carolina HIV Prevention Community Planning Leadership Summit (CPLS) was also designed with a twofold purpose: 1) to strengthen the community planning process by developing the knowledge and skills of local prevention providers; and 2) to enhance communication between HIV prevention consumers and providers, specifically through the use of town hall meetings and networking luncheons. The next CPLS is tentatively scheduled for April 2005.

#### Parity:

In order to achieve parity, the South Carolina HIV Prevention Community Planning Group will continue to coordinate an annual strategic planning retreat, provide new member orientation, offer training at CPG meetings and monthly workshops, and support participation in state and national conferences.

All members of the CPG are offered a thorough orientation, as soon as possible after appointment. The CPG conducts a one-day new member orientation class. The goal of the new member orientation and the annual retreat is to prepare members to participate fully in the community planning process. Formerly, the agenda for new member orientation included a knowledge test on HIV/AIDS/STI and viewing the videocassette tape entitled “HIV Prevention Community Planning: Partners in Prevention Community Planning Overview”. This was followed by a review of the historical perspective of community planning in South Carolina, the CPG’s governing documents such as the CDC Guidance, bylaws, and policies and procedures. At the conclusion of the orientation the training staff entertains questions, and new members complete evaluation forms so that improvements can be made to the next class. New member orientation will now incorporate the information contained in the new *Guidance*.

Additionally, each new member is paired with an existing CPG member who serves as a “mentor”. Mentors are available during meetings and other events to educate and explain the planning procedures and other information new members may need. The orientation and mentor process will continue during 2004.

Skills building training is provided throughout the year for both new and existing CPG members to enhance their ability to participate in the planning process. The Technical Assistance and

Evaluation Committee uses the meeting evaluation forms to select topics and schedule trainings at regularly scheduled CPG meetings or workshops. Periodically, DHEC Division of STD/HIV based on needs expressed by CPG members, as well as HIV Prevention Collaborations and public health department personnel coordinates workshops and satellite broadcasts. A scholarship process was established to give members an opportunity to participate in national conferences such as the National HIV Prevention Conference and United States Conference on AIDS. Attendance to the National Community Planning Leadership Summit for HIV Prevention is usually limited to the Co-Chairs and/or Executive Committee members due to cost.

**Community planning goal one will be sustained or improved over the five-year project period of this program announcement by:**

- The CPG will achieve full membership capacity of 30 members by:
  - ❖ The Membership Committee will review the composition of the CPG on a regular basis and determine priority membership needs.
  - ❖ The Membership Committee will continue to solicit applications from epidemiologists and evaluation researchers from colleges/universities, professional associations, and other DHEC programs.
  - ❖ The Membership Committee will facilitate new membership intake and conduct new member orientation twice annually.
- All CPG members will complete the *Community Planning Membership Survey*.
- DHEC and the CPG will work together to implement community planning, especially PIR, as defined by the CDC in the *HIV Prevention Community Planning Guidance* dated July 10, 2003.

**Goal Two – Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction, with HIV-infected persons prioritized as the highest priority and uninfected, high-risk populations prioritized based on community needs.**

**Objective D: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.**

Epidemiologic Profile:

The revisions to the *South Carolina's Epidemiologic Profile of HIV/AIDS* were completed on March 21, 2003 by DHEC surveillance and STD/HIV program staff with input from the state epidemiologist. The purpose of the epidemiologic profile is to provide information about defined populations at high risk for HIV infection for the CPG to consider in the prioritization process. See Attachment 3 for a copy of the updated Epi Profile.

An updated consolidated Epidemiologic Profile for prevention and care services providers will be completed in by March 2004. The CDC guidance for developing consolidated profiles will be used. The new profile will be used to update/develop the new Prevention Plan to be completed by the end of 2004.

### **Community Services Assessment:**

The Community Services Assessment (CSA) focuses on one or more high priority populations (i.e., substantially contributing to new HIV infections in a jurisdiction) identified in the epidemiologic profile. South Carolina's CSA was divided into three phases. The following table summarizes the different phases, tasks to be completed within each phase, and anticipated timeframe.

<b>PHASES</b>	<b>ANTICIPATED TIMEFRAME</b>	<b>TASKS TO BE COMPLETED</b>
Phase I	2001	Phase I of the community services assessment consisted of collecting information regarding the priority populations through secondary data sources; conducting focus groups with two prevention provider groups, and surveying providers to determine the extent to which prevention services were available, accessible and appropriate for the priority populations.
Phase II	2002-2003	Phase II of the community services assessment will focus on obtaining information from the priority target populations through focus groups, surveys, town hall meetings, interviews, etc.
Phase III	2003-2004	Phase II of the community services assessment will include round table discussion with representatives of the target populations to share results of Phase II assessment and obtain feedback on the meaning of the results, verification and to learn recommendations for intervention strategies.

STD/HIV Division staff and the HIV Prevention Community Planning Group (CPG) Needs Assessment Committee continued population-focused needs assessment activities in 2003. The participant distribution was from rural and metropolitan areas around the state as well as age cross-section and preference for HIV negative persons. The plan included four (4) African American heterosexual men focus groups, four (4) African American heterosexual women, three (3) African American MSM, and three (3) White MSM focus groups. Six groups have been completed by June 2003 and four will be completed by the end of this calendar year. Key questions focus on obtaining behavioral and social context information that will be used by the CPG and STD/HIV staff to determine HIV/STD intervention strategies, where to target efforts (specific congregation sites, areas of risk behavior, etc).

Phase III will begin in 2004. This assessment will involve round table discussions with representatives of each priority population, beginning with HIV positive persons, to further

explore and define key findings related to the target populations being served and the geographical coverage of interventions or programs. Additionally, risk behaviors, social context and HIV prevention needs will be determined. Discussions will focus on obtaining further insights and recommendations of behaviors and prevention strategies. Once Phase III is completed, the information collected will be presented to the CPG and used in its next prioritization process.

**Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.**

Target Populations:

The size of at-risk populations; measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence); and prevalence of risky behaviors in the population were all considered by the Needs Assessment Committee in setting priorities for target populations in 2003. Another criteria used to establish priorities were whether or not the population was “CDC required” such as HIV positive persons.

DHEC staff distributed and reviewed the *South Carolina’s Epidemiologic Profile* (March 21, 2003) with the CPG. The Needs Assessment Committee presented their recommendations for changing the priority order of populations at the July 23, 2003 CPG meeting. After the presentation, the CPG members discussed the recommendations and voted to ratify the new ranked populations.

Seven target populations were identified by the CPG and rank ordered by priority, in terms of their contribution to new HIV infections. Each priority population is defined by transmission risk, gender, age, race/ethnicity, and HIV status. They are 1) HIV Positive Persons, 2) African American Men who have Sex with Men, Ages 15-44; 3) African American Women who have Sex with Men, Ages 15-44; 4) African American Men who have Sex with Women, Ages 15-44; 5) White Men who have Sex with Men, Ages 15-44; 6) Injection Drug Users, Ages 20-44; and 7) Hispanic/Latino.

A similar process will be used in 2004 to review and prioritize populations based on the updated Epidemiologic Profile.

**Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.**

Prevention Activities/Interventions:

Initially, the CPG only prioritized health education/risk reduction (HE/RR) interventions. In 2003, the CPG revisit priority interventions to determine if additional intervention types should be included for each population.

The CPG utilized the Behavioral and Social Science Volunteer Program to identify a local scientist that would be willing to work with the CPG to help prioritize prevention

activities/interventions by risk population and their ability to have the greatest impact on decreasing new infections. Dr. Leonard Goodwin a professor at South Carolina State University Department of Psychology and Sociology was identified and agreed to co-chair the Behavioral and Social Science (BSS) Committee in conjunction with another CPG member. The purpose of this committee is to facilitate the selection of interventions and strategies for each high-risk population identified.

Division staff reviewed HIV intervention types with the CPG using the *HIV Prevention Programs Health Education Risk Reduction Guidelines*, which was produced by the Health Education/Risk Reduction Quality Assurance Committee Ad Hoc Committee. The guidelines provide a clear description and definition (including quality assurance standards) for each of the intervention types.

Additionally, the BSS Committee reviewed additional literature to identify effective intervention types for the priority populations selected by the CPG. These same documents were used to design a 1 - page intervention recommendation sheet for each target population containing six categories of information: 1) subpopulations of concern, 2) risk behaviors, 3) intervention outcomes, 4) intervention types recommended, 5) rationale supporting the recommendation of a specific intervention type, and 6) resources. Some of the documents referenced are listed below.

- Addressing HIV/AIDS...Latino Perspectives & Policy Recommendations by National Alliance of State and Territorial AIDS Directors (NASTAD)
- Compendium of HIV Prevention Interventions with Evidence of Effectiveness from CDC's HIV/AIDS Prevention Research Synthesis Project
- Fact Sheets of Effective HIV Prevention Interventions compiled by Health Education Training Centers Alliance of Texas – San Antonio, University of Texas Southwestern Medical Center - Dallas, Texas Department of Health - Austin
- Incorporating HIV Prevention into the Medical Care of Persons Living with HIV HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments by CDC
- Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States, 2003 by CDC

The CPG used the one page information sheets at the August 18, 2003 CPG meeting to ratify the list of intervention types that would have the greatest impact on decreasing new infections in the priority population.

TARGET POPULATIONS BY RANK ORDER	INTERVENTIONS TYPES
1. HIV Positive Persons	Individual Level Intervention Group Level Intervention – Support Group Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services
2. African American Men who have Sex with Men (MSM), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building

	Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
3. African American Women who have Sex with Men (WSM), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
4. African American Men who have Sex with Women (MSW), Ages 15-44	Individual Level Intervention Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Capacity Building Community Level Intervention
5. White Men who have Sex with Men (MSM), Ages 15-44	Group Level Intervention – Skills Building Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Community Level Intervention
6. Injection Drug Users, Ages 20-44	Individual Level Intervention Group Level Intervention – Skills Building Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Community Level Intervention Other
7. Hispanic/Latino	Individual Level Intervention Group Level Intervention – Skills Building Group Level Intervention – Support Group Outreach Prevention Case Management Counseling & Testing Partner Counseling and Referral Services Health Communication/Public Information Capacity Building

**Community planning goal two will be sustained or improved over the five-year project period of this program announcement by:**

- DHEC will develop a consolidated epidemiologic profile for prevention and care planning by March 2004 for the CPG to utilize in developing a revised Prevention Plan.

- The CPG will complete Phases II and III of the community services assessment and use the collected data to make appropriate science-based prevention activities/interventions recommendations.
- The CPG will revise Chapters 2 and 3 titled Needs Assessment and Priority Populations and Interventions respectively.
- The CPG and DHEC will update the gap analysis.
- The CPG will expand the approved list of interventions to include specific models that is based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended consumers for cultural appropriateness, relevance and acceptability.
- DHEC and the CPG will work together to implement community planning as defined by the CDC in the *HIV Prevention Community Planning Guidance* dated July 10, 2003.

**Goal Three – Community Planning ensures that HIV prevention resources target priorities set forth in the Comprehensive HIV Prevention Plan.**

**Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.**

All funds received from CDC for HIV prevention services are distributed either to HIV prevention contractors and to local health departments. Some resources are retained at the state office to provide capacity building training, quality assurance, program monitoring and oversight, evaluation, and community planning assistance.

Table 1 below summarizes the linkages by listing the 2004 Application proposed populations and interventions, estimated proportion of 2004 resources allocated by population, and the 2002 – 2004 SC HIV Prevention Plan Priority populations and interventions as amended in 2003.

**Table 1. Linkage Between The Application and The Plan**

<b>2004 Application Proposed Populations and Interventions</b>	<b>Estimated CDC HIV Prevention Funding Proportion To be Allocated with 2004 Funds</b>	<b>2002-2004 SC HIV Prevention Plan Priority Populations (amended rankings from 2003 for 2004)</b>
1. HIV + (ILI, PCM, GLI-SG, GLI-SB, CT, PCRS)	47%	1. HIV + (ILI, PCM, GLI-SG, OUT, CT, PCRS)
2. African Amer. MSM, 15 – 44 (ILI, GLI-SB, CT, CB, HC/PI, OUT, PCRS)	6%	2. African Amer. MSM, 15 – 44 (ILI, GLI-SB, CT, PCRS PCM, CB, CLI)

3. African Amer. WSM, 15 – 44 ( <b>ILI, GLI-SB, CT, HC/PI, CB, OUT, PCRS</b> )	15%	3. African Amer. WSM, 15 – 44 ( <b>ILI, GLI-SB, CT, PCRS PCM, CB, CLI</b> )
4. African Amer. MSW ( <b>ILI, GLI-SB, CT, PCM, CB, HC/PI, OUT, PCRS</b> )	9%	4. African Amer. MSW ( <b>ILI, GLI-SB, CT, PCRS PCM, CB, CLI</b> )
5. White MSM, 15 – 44 ( <b>CT, GLI-SB, HC/PI, CB, PCRS</b> )	4%	5. White MSM, 15 – 44 ( <b>CT, PCRS, GLI-SB, PCM, CLI</b> )
6. IDU ( <b>CT, PCRS, OUT, ILI</b> )	2%	6. IDU ( <b>ILI, GLI-SB, OUT, CT, PCRS PCM, CLI, other</b> )
7. Hispanic ( <b>GLI-SB, OUT, CT, PCRS, HC/PI, CB</b> )	3%	7. Hispanic ( <b>ILI, GLI-SB, GLI-SG, OUT, CT, PCRS PCM, HC/PI, CB</b> )

**NOTES:**

1. Populations: MSM = Men who have Sex with Men; WSM = Women who have Sex with Men; IDU = Injecting Drug User; MSW = Men who have Sex with Women
2. Interventions: ILI = Individual Level; GLI = Group Level; CLI = Community Level; PCM = Prevention Case Management; OUT = Outreach; CT = Counseling and Testing (inclusive of Community Based Counseling and Testing); CB = Capacity Building; HC/PI = Health Communications/Public Information.
  - **Bolded** interventions indicate consistency between Application and Plan.

The proposed funding allocations by population and intervention type is essentially consistent with the priorities in the Plan as reflected above. There are some populations such as African American Men who Have Sex With Men that appears to not be consistent the plan in terms of its funding proportion versus #2 ranking. This mostly reflects the challenges of prevention providers to reach openly identifying African American MSM. Many providers attempt to reach this population within the African American Men Who Sex with Women population which includes non-self identifying AAMSM in many settings.

**Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.**

The chart in Attachment 4 demonstrates the relationship between the funded interventions and Prevention Plan priorities. The chart shows the number of providers/intervention services and other supportive services that will be funded with CDC funds compared to the priority interventions specified in the Prevention Plan. The chart also reflects the total health department resources allocated to intervention services through state funds, and other federal funds, e.g. alcohol and drug abuse block grant funds. These other resources are used to support counseling and testing, PCRS, and HE/RR interventions. Overall, approximately 90% of proposed interventions are consistent to the latest priorities ranked by the CPG.

**Performance Indicators:**

Indicator	Baseline	Target 2004	Target 2008
E.1: Proportion of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of	71%	86%	100%

each population.[Representativeness]			
E.2: Proportion of key attributes of an HIV prevention planning process that CPG membership agreed have occurred. [Community planning implementation]	87%	94%	100%
E.3: Percent of prevention interventions/other supporting activities in the health department CDC funding application specified as a priority in the comprehensive HIV prevention plan. [Linkages between community planning priorities and funding priorities]	90%	95%	95%
E.4: Percent of health department-funded prevention interventions/other supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan. [Linkages between community planning priorities and funding priorities]	90%	90%	90%

## Indicators Data Selection:

### E. 1. Representation of Community Planning Group

#### Baseline:

Based on the 2002 and the 2003 CPG Membership Survey, the number of members by risk/race/gender that fell into one of the 7 priority populations was counted. For both 2002 and 2003, 5 of the 7 populations (71%) are reflected through the membership of the CPG.

#### Targets:

Based on current membership (2003) and the new priority populations for 2004 [1) HIV+, 2) African American MSM, 3) Heterosexual African American Men, 4) Heterosexual African American Women, 5) White MSM, 6) IDUs, and 7) Hispanic/Latino], 7 of the 7 priority populations are reflected by CPG members. However, the numbers for IDU and Hispanic are based on one member each, so it may not be a stable number depending on changes that may occur in membership for 2004.

The target for 2004 is 86 percent representation, or 6 of the 7 populations and the 2008 target is 100% representation.

### E. 2. CPG Agreement with Key Attributes of Planning Process

#### Baseline:

The Technical Assistance Guideline suggests three options for setting baseline for Indicator E.2. The **BEST** option was applied to calculate an overall percentage of agreement as recommended by the guidelines. The Community Planning Membership Survey was administered at the June 2003 meeting with 16 members completing the survey. The overall percentage of agreement was calculated as follows:

Total # of Agrees = 698

Total # of Disagrees = 53

Agrees + Disagrees = 751

$\% \text{ Agreement} = 698 / 751 = 93\% \quad (N=16)$

The guidelines state that the 52 critical attributes correspond to the objectives of the CPG, and if the attributes are present in the community planning process, it can be deduced that the objectives are being met. Therefore, additional focus was given to each of the 52 attributes to determine which ones the CPG perceived occurred in the planning process. The Health Department with guidance from the CPG co-chairs set 85 percent as the minimal level of agreement for each of the 52 attributes. Therefore, a percentage of agreement (based on valid responses) was calculated for each of the attributes. Forty-five (45) of the 52 attributes had at least an 85 percent level of agreement. For that reason, the baseline reflects this proportion, 45 of 52 or 87 percent.

Targets:

Using future CPG meetings to review goals, objectives and attributes of the planning process the number of attributes, which the CPG perceives as having occurred should increase. However, factoring into this process that almost 40% of the group have only been members for one-year and that new members are continually joining, full consensus on all attributes may be difficult to obtain for 2004.

The 2004 target will be set at 94 percent (49 of 52) and the 2008 target will be 100% (52 of 52).

### **E. 3. Health Department CDC-Funded Interventions Consistent with Plan**

Baseline:

The baseline was estimated by listing the number of providers to be funded with CDC funds by intervention and other supportive services type and matching the number to the total interventions reflected in the Prevention Plan. The chart in Attachment 4 was used to count the total number of interventions to be funded (numerator) divided by the total number of interventions prioritized in the Plan. Nine of ten interventions matched (90%).

Targets:

One and five year targets were selected based on planned updates to the Plan in 2004 and new contract selection process that will reflect priority interventions in the new Plan.

### **E. 4. Health Department Funded Interventions Consistent with Priorities in the Plan**

Baseline:

The baseline was estimated by listing the number of providers to be funded with both CDC funds and other health department resources by intervention and other supportive services type and matching the number to the total interventions reflected in the Prevention Plan. The chart in Attachment 4 was used to count the total number of funded interventions (numerator) divided by the total number of interventions prioritized in the Plan. Nine of ten interventions matched (90%).

Targets:

One and five year targets were selected based on planned updates to the Plan in 2004 and new contract selection process that will reflect priority interventions in the new Plan. Ninety percent was selected as a target versus 95% due to likelihood that other funding resources may have specific requirements that may not match the HIV prevention plan.

## 2. HIV Prevention Activities

Overall Performance Indicators	Baseline	Target 2004	Target 2008
A. 1 Annual number of HIV infections	898	853	674
A. 2 Annual number of HIV infections among 13 – 24 yr olds	113	96	93

### Indicators Data Selection:

#### A. 1. Newly diagnosed HIV infections

##### Baseline:

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, the BEST method was used to determine the baseline for this overall indicator. The number of newly diagnosed HIV/AIDS cases in South Carolina during calendar year 2002 was 898.

##### Targets:

The number of newly diagnosed HIV/AIDS cases for 1998 - 2002 was analyzed for trends. Each year the number of diagnosed cases has been decreasing. From 1998 - 2002, there has been a 25% decrease in number of new diagnoses; therefore, the 2008 target of 674 is 25% fewer cases than the baseline number (898). The one-year target for 2004 (853) is 5% fewer cases than the baseline based on a 5% decline observed between 2000 – 2002.

Data Source: HIV/AIDS Reporting System (HARS)

#### A. 2. Newly diagnosed HIV infections , 13 – 24 years of age

##### Baseline:

The BEST method was used to determine the baseline for this indicator. The number of newly diagnosed HIV/AIDS cases among persons 13 – 24 years of age in calendar year 2002 was 113.

##### Targets:

The number of newly diagnosed HIV/AIDS cases in 1998 – 2002 was analyzed for trends. The number of new cases has been more stable than total cases for all age groups but did decrease 18% between 1998 and 2002. Therefore, based on this trend, the 2008 target of 93 is 18% fewer cases than the baseline (113). The one-year target for 2004 (96) is 15% fewer cases than the baseline based on a 15% decline observed between 2000 – 2002.

Data Source: HIV/AIDS Reporting System (HARS)

#### a. Counseling, Testing, and Referral (CTR)

**i. Plan to improve efforts to identify newly infected persons**

- CTS services will continue to be offered through each county health department (46 sites), one mobile van, and 7 contracts with community organizations (HIV Collaborations). Over 46,000 tests were conducted in CY2002 and 1.4% were HIV positive. The positivity rate of newly diagnosed persons was 0.7% (verified by linking to HARS). The table below summarizes the number of tests done in 2002 by primary provider, number and % positive.

<b>Provider/Site – CY2002</b>	<b>No. Tested</b>	<b>Total Number Positive</b>	<b>Percent Positive</b>	<b>Number New Positive*</b>	<b>Percent New Positive</b>
County Health Departments					
Voluntary HIV Only	4,558	386	8.5%	156	3.4%
DHEC Mobile Van	803	10	1.2%	4	0.5%
Total All Clinics**/Van	46,613	681	1.5%	324	0.7%
HIV Collaborations	1,286	5	0.4%	(unk)	
Total	47,899	686	1.4%		

\* Reflects people who are verified as newly diagnosed by linking to HARS; 148 persons could not be verified and some may be newly diagnosed.

\*\* HIV, STD, Family Planning, TB, other clinics

The following activities will be conducted to improve efforts to identify HIV infected persons in 2004:

- Work with collaborations to target testing to high risk persons (social networks of known HIV infected persons) by encouraging meetings and interaction with health department DIS staff to identify locations and settings where persons may be reached and testing may be provided with little wait time.
- Explore setting up incentive program in districts of highest incidence (Columbia area, Pee Dee, Charleston, Greenville, Sumter) for health dept. staff to encourage known positives to refer partners or persons “associated” or “suspected” of being exposed to HIV to be tested at the health dept or collaboration office. This may include collaboration with HIV care consortia/Title III sites.
- Modify syphilis elimination van screening approach from “one-shot” screenings at health fairs, low-risk events, to repeated visits in an identified neighborhood or setting most likely to recruit persons at greater risk for HIV and syphilis.

**ii. Plan to improve provision of test results (especially HIV positive results)**

- Current policy requires at least 3 attempts to notify persons with positive test results who don't keep their appointments. It is estimated through chart reviews that approximately 90% of persons testing positive in health departments receive their test results.
- Initiating rapid testing will significantly improve test results counseling for clients seeking HIV testing services (rapid tests will not be used for clients tested routinely in STD, Family Planning clinics). In January 2004, four districts will pilot test rapid testing for 60 days, and it is expected by April 2004, all districts will offer rapid testing to clients seeking HIV testing and counseling, STD clinic clients of highest risk, and possibly TB clients of highest risk. Please see Quality Assurance section for more information regarding training and quality assurance system developments.
- Provision of test results for clients testing negative in STD clinics will be improved by implementing telephone test results procedures and better documentation in the automated tracking system database.
- The quality assurance system (explained in the Quality Assurance system section) and site visits will routinely monitor rates and staff will provide follow – up technical assistance for sites that do not meet standard or target rates.
- Finally, the method of collecting test results counseling will be changed as the current system is not being used completely by local staff so rates of test result counseling is artificially low. The STD/HIV Division plans to design a new scannable form that is consistent with the revised CTS data elements. This scannable form will capture all elements including test results counseling and will be completed for each person receiving HIV testing services. The Division is waiting for final specifications to be provided by CDC in order to purchase any needed hardware (scanners).

### **iii. Plan to work with medical care entities to encourage and support routine HIV screening in high prevalence settings**

- Staff will identify the health care facilities serving populations in counties with HIV prevalence. This may include community health centers, hospitals. Discussions to promote screening and provide information on simplified screening procedures will occur with key staff at these facilities to explore feasibility of routine screening. It is expected that cost issues will be the greatest barrier encountered from these facilities, e.g. cost of testing.
- Staff will write an article for the Bureau of Disease Control's Epi Notes to provide information and summary of CDC recommendations. EPI Notes is a quarterly publication mailed by DHEC to all primary care providers, hospitals, etc.

### **iv. Plan to support providers of CTR services**

- Prevention counseling training will be provided at least 5 times in 2004 for new staff. Trainings will be offered in different regions to alleviate travel issues.
- Quarterly meetings with DIS, Program Managers provide opportunities to discuss program indicators, barriers or challenges, and other updates to ensure quality services.
- Rapid testing training will be provided in late 2003 and early 2004 to local health department staff. On-going technical assistance and quality assurance for rapid testing will be provided by state office STD/HIV Division and Bureau of Labs staff.

- Routine quality assurance visits provide an opportunity to assess how HIV CTS are provided, provide feedback and technical assistance if needed. Districts receive at least one visit per year by a team of STD/HIV Division staff (nurse, social work, DIS, and health education). These visits will continue in 2004.
- In 2003, Ryan White Care staff and HIV prevention staff initiated meetings with local care and health department CTR staff to discuss current referral systems for newly diagnosed persons with HIV into care. The meetings clarified current care providers, how to enhance an active referral process, assessing completeness of referral and follow – up for persons who do not keep initial appointments. Staff are revising consent procedures to address follow-up contact (in some areas Ryan White providers may have more staff capacity to do follow-up). These meetings will continue in 2004 and the new CTR data system should allow for documenting and reporting on the number of clients referred who kept appointments.

### Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
B.1: Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites. [Overall HIV positive test yield]	0.7%	1.0%	1.5%
B.2: Percent of newly identified, confirmed HIV-positive test results returned to clients. [Knowledge of HIV positive serostatus]	90%	95%	95%
B.3: Percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's target set in B.1. [Targeted services]	42%	60%	75%

### Indicators Data Selection:

#### B. 1. Newly identified, confirmed HIV positive test results

##### Baseline:

The BEST method was used to select the baseline: the proportion of newly identified persons (verified) among all persons tested with previous negative or unknown HIV status in CY 2002.

##### Targets:

Five year trend data on newly identified positive persons is not available, only the total positivity rate for all persons tests (both previously diagnosed and newly diagnosed). One and five year targets were selected as feasible measures with better targeting. 5 districts had a positivity rate of 1% or more for new diagnoses, therefore 1% was selected as the one year target. One district has a rate of 1.5% for newly diagnosed positives and was the basis for the 5 year target.

Data Source: SC CTS Data System

## **B. 2. Positive Persons Receiving Test Results**

### Baseline:

The BETTER method was used to select the baseline for this indicator. The current data system designed to measure the number of clients informed of a newly diagnosed test result does not reflect accurate, complete data. For various reasons, there is incomplete data entry, therefore, a chart review was done for all persons testing positive (confirmed) in local health department sites during the 3 month period of May – July 2003. Based on the results of the chart review, 90% of positive persons (both previously and newly diagnosed) were informed of test results.

### Targets:

The CDC national HIV Strategic Plan Goal 2 benchmark of 95% was used to select the one and five year target levels.

Data Source: SC CTS Data System

## **B. 3. Facilities' Positive Test Prevalence**

### Baseline:

The BETTER method was used to determine the baseline. In 2002, 42% or 5 of 12 health districts (representing approximately 50 sites) reported 0.7% or more newly identified and confirmed HIV positive test results among clients of unknown or negative serostatus.

### Targets:

Trend data are not available therefore measures were set for one and five year targets based on feasible goals if testing is modified/targeting more higher risk persons.

### **b. PCRS**

#### **i. Plan to provide PCRS, including PCRS for clients from non-health department settings.**

- South Carolina has been providing partner counseling and referral services to all persons diagnosed with HIV infection or AIDS since 1988. All persons newly diagnosed with HIV in local health departments and reported by physicians, hospitals, correctional facilities and other medical sites reported to HIV Surveillance are followed up by local DIS staff to provide PCRS services. During 2002, local health department staff provided partner counseling services to 877 HIV infected persons who named 1688 sex/needle-sharing partners. Approximately 30% were persons diagnosed in local health departments, and 70% were diagnosed by other providers and reported to DHEC's HIV surveillance system.
- Staff will continue to provide partner referral services in 2004. About 41 DIS staff in local health departments provide integrated HIV and STD services, and PCRS is provided for HIV and syphilis. STD/HIV Division staff will monitor partner referral data to evaluate effectiveness, client acceptance, staff capacity to provide services (particularly in areas of high case loads).

## Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
C.1: Percent of contacts with unknown or negative serostatus receiving an HIV test after PCRS notification. [Contact use of services]	73%	75%	75%
C.2: Percent of contacts with a newly identified, confirmed HIV positive test among contacts who are tested. [Knowledge of serostatus by newly identified HIV positive contacts]	13%	16%	18%
C.3: Percent of contacts with a known, confirmed HIV-positive test among all contacts. [Contacts known to be HIV positives]	48%	54%	65%

### Indicators Data Selection:

#### C. 1. Contacts receiving HIV test

##### Baseline:

The BEST method was used to calculate the baseline. In 2002, the proportion of partners receiving PCRS with no documentation of previous positive test and who received a new test was 73%.

##### Targets:

Targets were set based on review of five year trend data (1998 – 2002) and discussion with DIS staff.

Data Source: STD MIS

#### C. 2. Contacts with newly identified HIV positive test

##### Baseline:

The BEST method was used for setting the baseline. 2002 data indicated 13% of the tested contacts were newly diagnosed with HIV.

##### Targets:

Targets were set based on review of five year trend data (1998 – 2002) and discussion with DIS staff.

Data Source: STD MIS

#### C. 3. Contacts with known HIV positive test among all contacts

##### Baseline:

The BEST method was used for setting the baseline. 2002 data indicated 48% of the tested contacts were newly diagnosed with HIV.

##### Targets:

Targets were set based on review of five year trend data\_(1998 – 2002) and discussion with DIS staff.

Data Source: STD MIS

**c. Prevention for HIV-Infected Persons**

**i. Plan to provide prevention services to people living with HIV/AIDS.**

- The community planning group prioritized HIV positive persons as number one in the state Comprehensive HIV Prevention Plan for South Carolina at the July 2003 meeting. As a priority population, state health department staff have also been working with local health department staff and contractors to begin redirect services focusing on this higher priority population for 2004. To assist with this shifting, prevention staff have teamed up with the Ryan White Care staff and hosted a joint meeting in September 2003 of local prevention and care providers to discuss the new initiative for HIV positives and to look at ways to enhance cooperative efforts. Additional meetings will be held in 2004 to look at integrating PCM and individual level prevention counseling activities with Ryan White settings and to closely link with local DIS staff providing partner notification services in order to target persons most likely to be HIV infected and refer to care.

**ii. Plan to provide financial assistance to CBOs and other HIV prevention providers (including local health departments).**

- Currently, financial assistance is provided to local health departments through 12 public health districts to provide CTR and PCRS. Social workers are also funded in the health districts to deliver prevention case management. Finally, 13 HE/RR contractors have been making a shift toward providing community based counseling and testing services and expanding to include individual level prevention and elements of PCM. State health department staff are currently working with the University of Texas Southwestern Medical Center to provide PCM training in October 2003. Division staff (Stan Wardlaw – PCM Consultant) will continue to provide training and technical assistance to local staff to increase skills and capacity of providers to implement this intervention. Staff will also work to clarify the role of non –licensed counselors/social workers to provide PCM services, a key issue among CBO providers at present.

**iii. Plan to encourage primary care clinics to integrate prevention and care services.**

- The majority of primary care clinics (community health centers) provide HIV testing services and nine sites also receive Ryan White Title III funds. About 7 of these sites use Title III funds to support HIV screening services to clients of their primary care facility. In 2004, STD/HIV Division staff will ensure that a contact list of all primary care sites is integrated with the mailing list for training updates and meetings to allow their staff to participate in relevant trainings. At least one training will focus on integrating prevention for positive persons based on CDC curricula/training information.

- Additionally, as mentioned above, a joint meeting of HIV prevention and Ryan White care providers (including the Title III – primary care clinic providers) was conducted on September 12, 2003. Follow – up meetings will occur in 2004 to discuss collaboration of prevention and care services.

### Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
I.1: Proportion of HIV infected persons that completed the intended number of sessions for Prevention Case Management. [Retention among infected persons]	72%	85%	90%
I.2: Percent of HIV infected persons who, after a specified period of participation in Prevention Case Management, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status. [Impact of PCM among infected persons]	66%	75%	85%

### Indicators Data Selection:

#### I.1 Retention of HIV Positive Persons in PCM

##### Baseline:

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, the **BETTER** method was applied to determine baseline for Indicator I.1. SC DHEC surveyed HIV prevention providers to determine the proportion of clients that completed PCM to HIV positive clients. To set the baseline for PCM to HIV positive clients, the Health Department set the completion standard as a minimum of 5 sessions. The baseline for PCM to positives is 72 percent.

##### Targets:

The Health Department will determine the completion criteria for PCM for the next funding cycle in the 4<sup>th</sup> quarter of 2003 with input from providers. The following targets are based on the current criterion.

The 2004 target for PCM will be 85 percent and the 2008 target will be 90 percent.

#### I.2 Impact of PCM Among Infected Persons

##### Baseline:

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, the **BETTER** method was applied to determine baseline for Indicator I.2. HIV prevention providers were asked to sample files of clients who are HIV positive and participated in PCM to determine the proportion of clients who report a change in behavioral risk. The baseline for prevention to positives is 66 percent.

##### Targets:

SC DHEC plans to provide additional trainings in PCM and guidance to providers during the next funding cycle. The focus of the training will be to improve providers' skills in assessing and addressing the risk behaviors of HIV positive persons. This should increase the percentage of clients who report lower sexual and drug using risk behaviors.

The 2004 target for PCM will be 75 percent and the 2008 target will be 85 percent.

#### **d. Health Education/Risk Reduction Services**

- There are currently 7 of 12 public health districts funded with HIV prevention funds to provide HE/RR including ILIs, GLIs, PCM, and outreach. During CY2004 funding will be continued with these public health districts to deliver HE/RR. Quarterly meetings of public health district staff will continue as a way to provide ongoing guidance, technical assistance, and training on implementing activities, data collection, and evaluation.
- Currently there are 17 contracts providing HE/RR prevention services. The 17 contracts include 11 HIV Prevention Collaborations, four projects targeting MSM and/or HIV+ persons, and 2 perinatal projects conducting PCM. The HIV Prevention Collaborations, based on the Ryan White model of care, are intended to bring local HIV prevention partners together to look at the epidemiologic profile in their jurisdiction and develop a local plan for prevention. Some of the contracts have been awarded to the same contractor. For example two of the Collaboration contractors also receive funds to conduct the projects targeting MSM and/or HIV+. Overall, there are 15 unique *contractors* for the 17 contracts.
- The contractors were obtained through a competitive bid process.
- The current contractors will continue to be funded during CY2004 at the current level of funding, and are listed in the budget.
- In attachment 5 is a table listing existing providers by prioritized populations and interventions that are currently funded for CY2003 and that will be funded in CY2004.
- These contractors meet quarterly and guidance, technical assistance, and training are provided on developing interventions plans, quality assurance, data collection, and evaluation.
- Information on the new initiative for HIV prevention for positives has been provided to the contractors at meetings during CY2003 and were in developing intervention plans for CY2004 that are inclusive of the new initiative.
- Based on the CY2004 Intervention Plans an estimated 8175 persons in priority population should be reached by HE/RR interventions. Below is a summary table:

<b>Intervention Type</b>	<b>Number of Providers (N=24)</b>	<b>Estimated # Persons to be Reached within priority populations</b>
ILI	11	323
GLI – SB	17	3498
GLI – SG	4	110
PCM	12	353
Outreach	12	3891
<b>Total # reached</b>		<b>8175</b>

- During CY2004 a new competitive Request For Proposal (RFP) process will be conducted. The new Request For Proposal (RFP) will be developed by mid-2004 and include details about the priority populations (including HIV+ as the number one priority) and the list of interventions that are in the SC Comprehensive HIV Prevention Plan.

## Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
H.1: Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and Prevention Case Management (PCM). [Retention]	ILI-85%  GLI-75%  PCM-71%	ILI-85%  GLI-85%  PCM-85%	ILI-90%  GLI-90%  PCM-90%
H.2: Proportion of the intended number of the target populations to be reached with any of the following specific interventions (ILI or GLI or PCM) who were actually reached. [Reach of intended target populations]	62%	75%	90%
H.3: The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM. [Impact of outreach and utilization of Services]	----	----	----

## Indicators Data Selection:

### H.1 Retention of Persons in ILI, GLI and PCM

#### Baseline:

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, the **BETTER** method was applied to determine baseline for Indicator H.1. SC DHEC surveyed HIV prevention providers to determine the proportion of clients that completed the following interventions ILI, GLI or PCM.

For ILIs and GLIs each provider set their own standards for completion based on the Health Department's Quality Assurance Guidelines for Interventions. To set the baseline for PCM, the Health Department set the completion standard as a minimum of 5 sessions. The baseline for ILI is 78 percent the baseline for GLI is 75 percent and 71 percent for PCM.

#### Targets:

Nearly all non-SCDHEC providers set the completion criterion for an ILI as one session. This was based on the client's HIV prevention risk reduction needs at the time of the initial session. SCDHEC will revisit the quality assurance standards for ILIs with all providers during 2004 to review completion criteria. SCDHEC anticipates that more providers will conduct more multi-session ILIs with high-risk and HIV positive clients during the next funding cycle.

The 2004 target for ILI will remain 85 percent and the 2008 target will be 90 percent.

Because of the characteristics of high-risk populations, the Health Department recognizes the challenges providers face in retaining clients for multiple group level sessions including one and three month follow-up booster sessions as required with some proven and effective GLI interventions.

The 2004 target for GLI will be 85 percent and the 2008 target will be 90 percent.

The Health Department will determine the completion criteria for PCM for the next funding cycle during the 4<sup>th</sup> quarter of 2003 with input from providers. The following targets are based on the current criterion.

The 2004 target for PCM will be 85 percent and the 2008 target will be 90 percent.

## **H.2 Reach of Intended Target Populations**

### Baseline:

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, the **BETTER** method was applied to determine baseline for Indicator H.2 since South Carolina does not currently collect client-level data.

Information from the 2003 Intervention Plans indicates that 2,663 clients from the priority populations were targeted for ILIs and GLIs. As of June 2003, 819 persons were reached. To estimate the total number reached for 2003, 819 was multiplied by 2 for a total estimated reached of 1,638 or 62 percent of the targeted priority population.

### Targets:

An improved review process of Intervention Planning Forms was implemented for the 2004 plans. This process assessed the contractor's capacity to reach the number of priority populations as indicated in their plan. Contractors have a better understanding of the characteristics of the target populations and the resources needed to conduct interventions.

The 2004 target is set at 75 percent and the 2008 target is set at 90 percent.

## **H.3 Impact of Outreach and Utilization of Services**

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, determining a baseline for this indicator using any of the three options was a challenge. SCDHEC does not have a tracking system in place to measure the impact of Outreach on service utilization. Additionally, surveys with providers did not yield reliable information. Therefore SCDHEC will work with providers to develop and implement a tracking system to follow-up on referrals to services through outreach contacts. *Please refer to the Outcome Monitoring section of SCDHEC's 2004 Evaluation Plan for more information.* Baseline and target measures will be provided in next year's application.

#### **e. Public Information**

- Public Information efforts are carried out by both the state health department staff, and by the local contractors and local public health district staff.
- At the state health department there is a toll-free AIDS/STD hotline number and hourly staff that respond to calls. The hotline serves as the first point of contact for information, particularly for high risk callers who want to remain anonymous. The hotline includes one Hispanic staff and advertising that includes hours of operation. Also, state health department staff provide public information assistance in securing and distributing media materials for national events like National Testing Day. State health department staff are responsible for coordinating the Federal Materials Review process as well as coordinating with the state health department (SCDHEC) Materials Review Committee. Finally, state health department staff are responsible for providing updates on HIV prevention activities to the STD/HIV Division web-page, including changes in the community planning process, changes in mailing addresses and e-mail addresses of contractors, contact information for local health department staff, changes to the HIV prevention plan, inclusion of the most recent CDC application, approved materials list.
- Among the contractors and local health department staff, some public information events like World AIDS Day and large group presentations are provided as requested. This helps to provide general community support for HIV prevention efforts in the state as well specific information about the epidemic, information on services, and information on risk reduction. During CY2004, 15 providers are planning to reach 7943 priority populations and 8692 general population participants with PI programs or a total of 16,635.
- These activities are generally supported in the CPG plan although not specifically prioritized. Given the new initiative, state staff have worked with local providers to reduce the number of PI events to put more emphasis on higher priority interventions being conducted with the priority populations including the number one priority population of HIV positives. The general rule of thumb being used with providers is that no more than 15% of their effort should be directed toward public information events for the general public.

#### **f. Perinatal Transmission Prevention**

- From the cascade of seven services stated in the supplemental announcement, South Carolina is primarily addressing “other HIV-related prevention and care services during the perinatal period”. The specific intervention is prevention case management for HIV infected women during the perinatal period in the three counties of highest HIV perinatally-acquired infection (Richland, Sumter, and Charleston) to facilitate access to other services and address prevention behavior change plans. Prevention case management (PCM) services will address many of the other steps (e.g. prenatal care, zidovudine use, avoidance of breast feeding) as appropriate for each woman.
- The target population that prevention case management services address are pregnant HIV infected women in Richland, Sumter, and Charleston counties. PCM staff will focus on women who receive inadequate prenatal care or no prenatal care and on HIV infected women with complex psychosocial issues who may not adhere to recommended antepartum or postpartum therapy and/or care plans.
- Other steps in the cascade to be addressed through coordination and linkages with existing systems, provider training and hospital policy development are education about the importance of HIV testing; voluntary HIV testing; for those who are positive, post-test counseling and zidovudine to reduce perinatal transmission, antiretrovirals for the benefit of the women’s own health.
- The provider target population will include prenatal providers and hospital-based staff providing labor and delivery services. Based on the responses to a needs assessment conducted during the fall of 2003 regarding knowledge of current screening and treatment recommendations, follow-up training and education activities will be planned and conducted.
- Prenatal care providers will be targeted for education, training and technical assistance to increase the number offering HIV testing to all pregnant women/exposed infants, appropriate treatment/care services for pregnant women and referrals to prevention services for pregnant women who test negative but may be at high risk for HIV infection. A statewide Obstetrics Task Force, formed under coordination of DHEC’s MCH program, will be used to obtain input on training needs, service needs, barriers, etc.
- During 2004, the Pediatric AIDS Project Coordinator/staff will continue collaboration with Obstetrics Task Force and obtain input on issues, concerns, barriers, solutions regarding offering of HIV testing to all pregnant women and HIV-exposed infants.
- Pediatric AIDS Project Coordinator/staff will continue communication and collaboration with existing MCH committees, organizations focusing on increasing rates of adequate prenatal care among high risk women to integrate HIV perinatal prevention messages/activities as appropriate.
- Pediatric AIDS Project Coordinator/staff will continue collaboration with HIV Prevention Collaborations statewide and the Women’s Resource Center in Columbia to design feasible education efforts based on consumer input to inform high risk women in these project service areas of the importance of HIV testing during pregnancy.
- The SC AIDS Training Network in collaboration with project planning/advisory team will complete in-service training, and education to at least 75% of prenatal care providers, especially those in areas of the state identified by follow-up analysis of perinatal HIV cases where women did not receive HIV testing.
- The 11 HIV prevention collaborations will provide priority HE/RR interventions targeting populations at risk identified by the statewide HIV prevention community planning group. The HIV prevention collaborations also cover the areas of the state with the highest prevalence of HIV among women. A key target population of collaborations is African American women at risk (which would include pregnant women at risk for HIV). The Pediatric AIDS Project

Coordinator (funded about 80% by Ryan White Title IV and 20% by CDC Perinatal Prevention funds) and staff will continue linkages/coordination with these existing projects to integrate practical, feasible education efforts to better inform pregnant women of the importance of HIV testing and available treatments to prevent perinatal transmission.

- Maternal and Child Health Services at DHEC includes a perinatal regionalization program. This program has linkages with the licensed perinatal hospitals and providers in the state. There are Obstetrical and Neonatal Outreach Educators located in six regional perinatal centers who have relationships with hospitals. STD/HIV Division, MCH, and Bureau of Disease Control will provide various educational opportunities for providers and hospital labor and delivery staff particularly in the Midlands, Wateree, Pee Dee and Waccamaw areas. These areas have highest rates of HIV among childbearing women.
- Education and outreach activities to pregnant women, especially those at high risk for HIV (e.g. low-income, substance users) to increase those who obtain prenatal care are currently provided by MCH program staff in local health departments, WIC programs, substance use programs, Healthy Start, March of Dimes and others. All HIV prevention counseling and testing staff, community collaborations conducting HIV prevention interventions to pregnant women, and Ryan White Care Act Title II and IV staff currently provide education to known HIV infected women who are pregnant and provide referrals to prenatal care providers. These services are available to women statewide.

### **Separate budget for these services**

A separate budget delineating perinatal prevention services for South Carolina's budget of \$125,302 is included in the budget narrative section.

### **SC's willingness to work with CDC to utilize a standardized approach to gathering HIV screening rates**

South Carolina is willing to work with CDC to assess HIV screening rates and has initiated plans to participate with the CDC-selected contractor (RTI) who will subcontract with selected hospitals to conduct chart reviews. The STD/HIV Division may also partner with DHEC's Division of Immunization to conduct chart reviews of infant records to assess HIV, STD and Hepatitis B screening and treatment.

South Carolina is also willing to work with CDC to use the "Perinatal HIV Prevention Programs Evaluation Protocol". DHEC has been conducting Enhanced Perinatal Surveillance activities for several years which has been essential to monitor perinatal prevention efforts. HIV surveillance program staff currently receive CDC funds to collect/review surveillance data to identify successes and missed opportunities for perinatal prevention activities. The HIV prevention program director and the HIV surveillance program director work closely to plan and implement these surveillance efforts. Additionally, there has been close collaboration to analyze and present data to MCH program staff, SC Medical Association MICH Committee, DHEC Commissioner's statewide Pediatric Advisory Committee, Ryan White Title II and IV providers and others to provide feedback and information on the effectiveness of perinatal HIV efforts and to discuss strategies for addressing systems barriers, specific populations to reach, etc. These efforts will continue during the project period for all perinatal cases statewide.

## Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
D.1: Proportion of women who receive an HIV test during pregnancy. [Pregnant women's knowledge of their serostatus]	81%	90%	100%
D.2: Proportion of HIV-infected pregnant women who receive appropriate interventions to prevent perinatal transmission. [Provision of preventive treatment to minimize perinatal HIV transmission]	80%	83%	90%
D.3: Proportion of HIV-infected pregnant women whose infants are perinatally infected. [Perinatal HIV transmission]	2%	2%	2%

### Indicators Selection:

#### D. 1. HIV testing during pregnancy

##### Baseline:

Data source 3 was used to select the baseline for this indicator: SC PRAMS data for 2000 (most recent year data available) indicated that 81.3% of women reported receiving an HIV test during pregnancy or delivery.

##### Targets:

CDC's target of 100% selected for the five year goal, 90% selected as one year goal as a feasible target. Note: South Carolina plans to participate in the pilot chart review of medical records review as part of CDC's contract to include 8 sites. The baseline and targets may change pending results of this data source.

#### D. 2. Perinatal prevention interventions

##### Baseline:

The baseline selected was based on CY 2001 enhanced perinatal surveillance and HIV/AIDS reporting system data. 80% of HIV infected pregnant women were prescribed 3 arms of AZT/treatment.

##### Targets:

Targets were based on trend data from 1994- 2001. In 1999 and 2000, 85% of HIV pregnant women received all three treatment arms; 83% is the 3- year average (1999 – 2001) and was selected for the one- year target. 90% was selected for the 5 year as a feasible goal.

Data Source: Enhanced perinatal surveillance and HIV/AIDS reporting system data.

#### D. 3. Perinatally infected infants

##### Baseline:

The baseline selected was based on CY 2001 enhanced perinatal surveillance and HIV/AIDS reporting system data. While data are still preliminary, there were 2 infants with known perinatally acquired HIV infection in the 2001 birth cohort.

### Targets:

Targets were based on trend data from 1994- 2001. While the three year average (1999 – 2001) indicates 3.3 infants were infected, 2 was selected since in 1999 and 2001 the number of infections was 2 in each year.

Data Source: Enhanced perinatal surveillance and HIV/AIDS reporting system

### **3. Quality Assurance**

The STD/HIV Division has developed quality assurance guidance and plans to address the program areas of CTR, PCRS, HE/RR, as well as data collection (see Evaluation section), training, and procedures. These efforts are described below and will continue in 2004.

#### **CTR – PCRS**

- The STD/HIV Program Site Visit Team will continue to visit the STD/HIV clinics in South Carolina's 12 health districts in order to monitor HIV/STD HE/RR, CTR, PCRS activities. STD/HIV program staff updated quality assurance tools and activities in July 2003 for use in conducting visits to local health districts. A specific tool addresses prevention counseling and the basic counseling elements is used with CTR and PCRS staff. Visits consist of record reviews, clinic environmental assessments, discussions with clients, observations of clinical exams and counseling sessions, and discussions with management staff regarding administrative access, and other program issues. Other topics discussed are quality assurance, enhanced surveillance initiatives, syphilis elimination efforts, training needs, partnerships with CBO organizations, and health providers. Hispanic outreach and interventions are also assessed. Written recommendations and findings (if any) are developed and provided to the district.
- Routine meetings with district Adult Health Services nurse/program and DIS supervisors are held to offer opportunities to provide program updates on STD/HIV clinical issues, electronic medical record systems, etc. Meetings will occur in late 2003/early 2004 to train staff on the revised CTS data collection form and data collection procedure to be used in South Carolina to reflect the revised CDC CTS data elements. In particular this new form and data collection procedure will become the database for CTS data and allow for monitoring the proportion of HIV positive clients who learn their test results. This new database will be monitored monthly initially to assess completeness of use, accuracy, etc.
- Completion of referrals for HIV positive persons is to be assessed by the counselor making the referral. The revised database will capture referral information and will be used to assess completion of referrals by each local health department/CBO.
- A committee of Bureau of Disease Control medical consultants, Bureau of Lab, STD/HIV Division and district staff has been meeting to plan and develop protocols for conducting rapid testing. Four districts will pilot in early 2004. A subgroup will develop a quality assurance system for rapid testing (which may include proficiency testing per CDC recommendations). This committee will remain functional in 2004 as all districts begin to provide rapid testing after the 60 – day pilot period.

- The social work consultant conducts site visits with HIV prevention contractors providing (including community-based counseling and testing) using the QA tool for prevention counseling and record reviews. Quarterly meetings are also held with contractors to discuss quality assurance issues around targeting testing to highest risk persons, risk assessment and documentation, specimen collection issues, etc. These activities will continue in 2004.
- Staff will continue to review PCRS data quarterly to assess the percentage of newly diagnosed persons from all sites who receive PCRS, contacts notified and tested, etc. Improvements including re-interviews of persons previously diagnosed will be discussed with DIS staff at quarterly supervisors meetings and local site visits. The quality of interviewing is assessed by observation at site visits and monitoring PCRS data to determine if QA standards are being met by each district/staff. These efforts will continue in 2004.

## **HE/RR**

- Two Division health education consultants will continue to observe HE/RR interventions, review district and contractor's local HIV implementation plans, make sure secondary and primary HIV prevention activities are culturally appropriate, science or evidence- based, and consistent with the CPG's plan. These activities are carried out by conducting quarterly meetings with local health department staff and the HIV prevention contractors. Additionally, site visits are conducted at least once per year but usually more often. As time permits, the two health education consultants also make quality assurance observations of interventions being delivered by staff and contractors using a quality assurance tool developed during CY2002. The quality assurance guide was developed for the local health department staff and contractors to use for consistency in describing interventions and reporting on interventions. This document also included QA standards and tools for observation that could be used by supervisory staff. During CY2003 this document was widely distributed during presentations on its usage to the CPG, local health department staff, and all contractors.
- During CY2004 state health education consultant staff will continue to train providers on the QA standards for HE/RR interventions and conduct observations and site visits as needed to assure the quality of programs.
- Staff will also explore using client satisfaction surveys to assess services provided. During site visits, state office staff include client interviews to assess services.

## **Policies and Procedures**

All health services programs in DHEC are presently updating program policies and procedures using a standard format. A committee reviews all drafts and then posts drafts on the DHEC intranet for local staff to review and comment. Final policies are posted on the DHEC intranet system for local staff to access. The Division also reviews policies directly with local staff during the updating and development. All policies include standards and procedures.

The following policies were developed during CY2003:

- CD4 and Viral Load Testing
- Testing Offenders for HIV, Hepatitis B Virus, and STDs

- Chlamydia and Gonorrhea Diagnostic Serology Urine Study
- Follow-up notification of Positive Test Results
- Provision of STD Test Results
- Provision of HIV test results
- Referral for Care and Services
- Use of non-oxynol-9 products for Family Planning and STD/HIV Clients

Partner notification and referral policies, rapid testing policies are currently being developed and should be complete by 2004.

Quality Assurance protocols/policies are also shared with local staff through quarterly meetings, district/contractor visits, and other formats. HE/RR Quality Assurance standards and prevention counseling standards have been developed and distributed.

#### **4. Evaluation**

- An updated copy of the evaluation plan for community planning, process and outcome monitoring and evaluation of HIV prevention activities CY2004 is provided in the Attachment 6.
- Several systems have been in place to monitor the implementation of programs in South Carolina. Below is a summary description by each program component.

a) *Counseling, Testing, and Referral Services (CTS)* demographic data are currently collected by utilizing the SCDHEC HIV Serology Request Form. Data on individuals tested in local health departments and contracted collaborations are keyed into a computer file at the Bureau of Laboratories and confidentially stored. The SCDHEC Laboratory conducts all HIV testing for the STD/HIV program. The STD/HIV program has developed an output report with the data required for the CDC counseling and testing reports.

Staff are currently revising the data collection system for 2004 based on CDC's revised CTS data elements. Plans are that a Teleform based system will be used with all data to be collected through a new CTS form used by local staff and scanned at each health district. Local data will be imported to a state level data system for reporting and monitoring.

b) *Partner Counseling and Referral Services (PCRS)* information is collected utilizing the CDC Interview Record form. All forms are sent to the STD/HIV Division on a monthly basis and entered in STD MIS and the HIV/AIDS Reporting System (HARS) for data maintenance and reporting.

c) *Prevention for Positives* process data will be collected through CTS, PCRS and through health education/risk reduction interventions.

d) *Health Education/Risk Reduction Services* (ILI, PCM, GLI, and Outreach) are primarily provided by AIDS Health Educators (AHEDS) and Social Workers in the 12 public health districts/local health departments (LHD), the 11 HIV Prevention Collaborations, 4 special

projects, and 2 perinatal contractors. Currently, paper pencil data entry forms (DEFs) are used to collect the required age, race, gender, and risk behavior on persons served, intervention types and descriptions, and evaluation information. Health department staff and prevention providers submit completed DEFs monthly to the program evaluation coordinator. All DEFs are reviewed for completeness and consistency. Data from the DEFs are entered into Microsoft ACCESS and exported to Excel for analysis. Data results/analysis are provided to contractors and LHD quarterly to provide feedback, and to CDC as required. This system will continue to be used until PEMS becomes available.

e) *Public Information* data are collected in two ways. The SCDHEC AIDS/STD Hotline staff utilize *EPI Info* to capture information from callers who speak to a staff person. After-hours calls are forwarded to the CDC National AIDS Hotline. An analysis is made of the data collected from calls answered by a staff person. Data collected include demographics, risk information if provided, type of information requested, and referral source to the hotline, (e.g. telephone directory listing, African American or Latino radio PSAs, etc.)

Public information activities provided by local collaborations/district staff are reported through the DEF reporting system described above.

f) *Perinatal Transmission Prevention* -

Outcome/indicator data is collected on all HIV infected women reported to HIV surveillance and matched with infant data from Vital Records. This data is collected through medical record review and includes: utilization of prenatal care by HIV infected women, HIV testing rates among women and their infants, access to ZDV for the purpose of reducing perinatal transmission during prepartum, intrapartum and postpartum periods, access to antiretrovirals during the perinatal period for the HIV-infected women's own health care, utilization of HIV-related services during the perinatal period, delivery type (vaginal/C-section), and postnatal breast-feeding rates among HIV-infected women. These measures are analyzed by geographic region, race, age, etc. Title IV case managers in regional and local sites provide lab information to HIV/AIDS Surveillance staff on pediatric HIV cases residing in their region, submit updates to the HIV/AIDS Surveillance program on the children's HIV/AIDS status within their region, and inform the Pediatric HIV/AIDS Surveillance Coordinator when children move in or out of the region. Pediatric surveillance data are monitored semi-annually.

South Carolina also conducts the PRAMS (Pregnancy Risk Assessment Survey) survey of a random sample of women recently delivering a live birth. The HIV testing question was revised in 2000 to: ***"At anytime during your most recent pregnancy or delivery did you have a blood test for HIV?"*** If no, reasons for not having an HIV test are assessed. PRAMS is a key tool used to determine the proportion of all pregnant women who are offered (and accept) HIV testing. PRAMS data is monitored as is available (2000 data was available in May 2003).

4) *Evaluating Linkages Between the Comprehensive HIV Prevention Plan and Application for Funding.* SCDHEC will continue to use the process outlined in Chapter 5 of the Evaluation Guidance (Volume 2 Supplemental Handbook) for conducting this evaluation activity. Data sources include the Comprehensive HIV Prevention Plan, Intervention Planning Forms and budgets from HIV prevention providers, information from the CTS and PCRS data collection systems, and interviews with health department staff and providers. Results of this process are

included in the CDC application and shared with CPG members during regularly scheduled meetings.

## Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
F.1: Proportion of providers reporting representative process monitoring data to the health department in compliance with CDC program announcement. [Capacity to monitor programs]	55%	75%	95%

### F.1 Representative Process Data

#### Baseline:

Based on the Guidelines for Setting Measures in the Technical Assistance Guidelines, the **BETTER** method was applied to determine baseline for Indicator F.1 since South Carolina does not currently collect client-level data. *NOTE: South Carolina does not collect ethnicity data from clients, therefore, measures are based on completeness of race, gender, age and HIV risk behavior variables only.*

Based on process data reported by 29 HIV prevention providers in 2003, 16 (**55%**) provided at least 85 percent complete data records based on race, sex, age and HIV risk behavior for ILIs, GLIs, and PCM. (*Outreach was not included in the count since South Carolina does not collect client level information*).

#### Targets:

With the addition of new data collection requirements (i.e., client-level data) and the introduction of an internet based data collection system (PEMS) in 2004, South Carolina will need to provide intensive training to improve the providers' capacity to report complete data.

The 2004 target will be set at 75 percent and the 2008 target will be 95 percent.

## 5. Capacity Building Activities

Technical assistance and capacity building needs are identified through the use of ongoing evaluations of workshop programs scheduled for the current year, at quarterly meetings of local public health district staff and the prevention contractors, at monthly CPG meetings, and with staff input based on quarterly narrative reports and site visits. The following is a list of ways that capacity building assistance will be provided in 2004 and over the five-year period:

- Continue to coordinate a schedule of monthly training workshops utilizing national CBA from CDC as well as other local providers.
- Continue quarterly meetings of HIV prevention staff (contractors and local public health district staff) to provide CBA.
- Provide assistance for HIV prevention staff to attend the annual HIV/STD Conference.

- Conduct periodic site visits to provide CBA as well as continue ongoing monitoring and assessment of needs of contractors and health department staff.
- Coordinate with the Office of Minority Health to provide assistance to minority CBOs linked with the HIV prevention contractors through OMH's AIDS Demonstration Project to Provide Capacity Assistance.
- Continue to conduct on-going evaluation and needs assessment of CPG members for CBA and coordinate CBA as needed.

A training needs assessment survey will be conducted during the 4<sup>th</sup> quarter of 2003 to obtain additional input for the development of capacity building assistance plan and training calendar. The survey has been developed by a University of South Carolina, School of Public Health graduate student with input and guidance from SCDHEC. The survey will assess the STD/HIV training needs of the HIV prevention contractors and DHEC professionals including Health Educators, Disease Intervention Specialists, Nurses and Social Workers. The survey includes the following topics: STD/HIV introductory topics/courses, implementation of HIV/AIDS prevention programs, evaluation of HIV/AIDS prevention programs, treatment and management of STDs/HIV and training preferences. A similar survey will be conducted in the fall of 2004 to identify training/capacity building needs for 2005.

## Performance Indicators

Indicators	Baseline	Target 2004	Target 2008
G.1: Proportion of providers who have received at least one health department supported capacity building assistance episodes, specifically in the form of trainings/workshops in the design, implementation or evaluation of science-based HIV prevention interventions. [Capacity building assistance in the design, implementation or evaluation of science based HIV prevention interventions.]	58%	90%	95%

### G.1 Capacity Building Assistance

#### Baseline:

The baseline option specified in the guidelines for setting measures for G.1 was used to set the baseline. Data from the 2003 training logs were reviewed to determine the number of HIV prevention providers that participated in or plan to attend a capacity building workshop in 2003. The total number of providers for 2003 is 26 and the number of providers that attended or plan to attend is 15 for a baseline of 58 percent.

#### Targets:

With the new HIV Prevention for Positive initiative, a number of trainings in 2004 will address the capacity needs of providers to reach HIV positive clients with ILIs, PCM, GLIs and Community based Counseling and Testing (CBCT). SC DHEC is requiring HIV providers to attend the appropriate training(s) to meet the new initiative.

The 2004 target is set at 90 percent and the 2008 target is set at 95 percent.

## **6. STD Prevention Activities**

The STD/HIV Division is integrated and provides both STD and HIV prevention services at the state and local level. Nursing staff in most county health departments have been cross trained in STD, HIV and TB clinical services. All STD/HIV nursing orders include a medical check-list that lists both pregnancy testing and STD/HIV screening and referral to other services (such as immunization evaluation and follow-up).

Local health department Disease Intervention Specialists who are responsible for partner notification services for infectious syphilis and HIV infection are cross trained. Several DIS staff are also trained to provide HIV test-decision and prevention counseling.

All 12 health districts implement integrated services in several of their respective clinic sites, an approach believed to be more client-friendly and an efficient use of staff. The STD/HIV Division, in collaboration with Family Planning, Immunization, TB and Bureau of Disease Control staff, provides a Preventive Health Training Course to nurses in local health departments. The course is offered three to four times annually and consists of a 10-day instructional course with up to six months of clinical preceptorship with an advanced practice registered nurse. More than half of the course time involves training on STDs.

Monthly training programs are conducted with local STD/HIV staff. Topics for training sessions are based on annual needs assessment. Additionally, the annual STD/HIV conference for health department, other agency and community based organization staff has an integrated agenda focusing on STD and HIV prevention and treatment topics. The conference is planned by a collaboration of state agency, university, and local community-based organizations including AIDS service organizations and HIV prevention provider organizations, Department of Education, local and state DHEC, Department of Alcohol and Other Drug Abuse Services, HIV Prevention Community Planning Group (CPG) members, and HIV Prevention Collaboration members.

STD/HIV staff collaborate to conduct syphilis elimination strategies that include integration of HIV prevention community planning, community education and outreach efforts. These coordinated efforts were in response to available CDC funding for syphilis elimination. The Division acquired a van and provides mobile clinical and outreach education services in counties of highest syphilis and HIV prevalence. HIV and syphilis screening, chlamydia screening, pregnancy testing, and hypertension and other screenings may be offered in coordination with other DHEC programs. The Division also supports syphilis and HIV screening in several county jails.

In summary, there is strong coordination of STD and HIV services at the state and local health department level for both surveillance and client services.

These same activities will be continued during Calendar Year 2004. Consultant and management staff will meet routinely to address barriers and other issues of concern, and to design feasible

solutions that ensure quality services while not duplicating or fragmenting service delivery. There are no new activities planned.

## **7. Collaboration and Coordination**

### **CDC directly funded CBOs**

South Carolina currently has one CDC directly funded CBO: South Carolina African American HIV/AIDS Council (SCAAHAC). The STD/HIV Division enjoys strong relationships with SCAAHAC including a contract for syphilis elimination services, providing routine data/information to assist in various funding proposals they may submit, joint program planning and training initiatives, support with HIV counseling and testing services through training, provision of condoms for condom distribution sites. A staff of SCAAHAC is a current CPG member and serves on the Youth Committee.

The STD/HIV Division Director communicates routinely with the Executive Director of SCAAHAC around program initiatives. This includes SCAAHAC's program plan and applications for funding. A draft application is reviewed by the Division Director prior to writing a letter of support. These activities will continue in 2004.

### **HIV/AIDS Care Programs**

The STD/HIV Division administers and manages Ryan White Title II, Title IV and HOPWA (Housing Opportunities for Persons With AIDS) care and treatment programs. STD/HIV prevention and care service staff routinely interact and provide coordinated activities. A well-established referral system is in place statewide between HIV counseling and testing sites and eleven local care consortia and the state AIDS Drug Assistance Program. A statewide resource guide contains a listing of prevention, care, and supportive services by county and is available for local health departments, care consortia, prevention collaborations, alcohol and drug abuse organizations and other providers. Many training workshops and quarterly meetings offered by the Division are attended by both prevention and care providers. Many local care consortia lead agencies and HIV prevention collaboration lead agencies are the same organization, as local providers increasingly see the connection between linking prevention services to care for HIV infected persons.

The DHEC STD/HIV program has developed an advisory committee comprised of people in the state who have been most influential in helping develop the state plan for service delivery to people with HIV disease. This committee includes consortia representatives (many also prevention providers/indirectly-funded CBO's), other Ryan White funded programs, other agency/community providers, and persons with HIV/AIDS and family members of persons with HIV/AIDS. This group is apprised on a regular basis of the progress of the service delivery system in the state, including the use of Title II funds. This group also served as the body to develop the Statewide Coordinated Statement of Need. The ADAP program has an advisory body of infectious disease physicians and program staff that meets annually to review the ADAP formulary and make recommendations for program improvements.

During calendar year 2004, these HIV prevention and care coordination activities will continue. Joint meetings will continue with local staff to enhance referral of newly diagnosed persons to care. As mentioned previously, follow-up to the September 2003 joint meeting of care and prevention providers on the new CDC prevention initiative and brainstorming initial issues/ideas for integrating prevention services with care providers will occur during the quarterly meetings of Ryan Whit staff in 2004.

### **Ryan White Title IV**

The Health Educator with the Ryan White Title IV program is in the STD/HIV Division and actively conducts prevention services in conjunction with CDC-prevention efforts. In 2004 these will include:

- Serving on the SC HIV Prevention Planning Group Youth Committee to ensure that youth issues and needs are met with emphasis on access to youth appropriate counseling and testing and referrals into care.
- Collaborating with HIV specialty providers at regional clinic sites to analyze intake records to determine referral origins and testing sites.
- Continue networking with at least 10 key organizations in Columbia, 4 in Charleston, 3 in Florence and 3 in the Upstate, serving at risk youth to provide on-going support for educating youth and referrals to primary care services including HIV counseling and testing.
- Provide and/or coordinate with existing education staff at least 2 education and referral sessions per quarter per youth-serving organization. Sessions will focus on basic HIV prevention; awareness of primary and HIV specialty care services and empowering youth to navigate within the care system.
- Coordinate with local HIV prevention providers and conduct community-delivered HIV counseling and testing services targeting adolescents at risk. Provide information regarding Title IV services for referrals.
- Coordinate training for Title IV case managers and social workers on prevention counseling for youth (to prevent/reduce transmission).

### **Substance abuse prevention**

The Department of Alcohol and Other Drug Abuse Services and DHEC have coordinated several prevention strategies during the past decade. A Memorandum of Agreement between the two agencies addresses active referral systems between county health departments and county alcohol and drug abuse agencies, training for public health staff on substance abuse risk assessment, and training for substance abuse on communicable disease issues. Additionally, DAODAS contracts with DHEC under its federal block requirement to allocate 15% of funds for HIV early intervention services. The contract supports HIV counseling and testing services conducted in several county substance abuse facilities in highest prevalence counties and supports local health department staff in the Columbia area to conduct community delivered screening targeting substance users.

This contract will continue during FY 2004 with additional funding to support community HIV counseling and testing in two areas of the state where there are no resources for these services (Pee Dee and Waccamaw).

### **Juvenile and adult criminal justice**

Several HIV prevention activities occur collaboratively with county and state correctional facilities. Current activities include counseling, testing and partner referral services in some county detention centers. Screening also includes other STD's such as syphilis. Screening most often is conducted by detention center staff. Local health department DIS staff provide HIV and syphilis partner referral services. The state Department of Juvenile Justice routinely screens youth upon entry for HIV, syphilis, gonorrhea, chlamydia and TB.

The state correctional facilities (DOC) currently house all HIV infected inmates in two facilities, one for men and one for women. Thus, DOC is better able to coordinate care and support services to infected inmates. All new inmates receive mandatory HIV screening and, if positive, are placed in the designated facility. The SC Department of Corrections estimates over 600 persons with HIV/AIDS are in the state system.

Ensuring a continuum of care for persons who may become incarcerated or who are released from correctional facilities is an emerging issue. An average of 100 persons are released each year. HIV infected inmates who have been taking medications while in the correctional facility need to have access to medical care and medications upon discharge to avoid disruption. DOC staff, state Ryan White Title II and Midlands consortia staff developed a discharge planning system to ensure HIV infected inmates are efficiently linked to the consortia and care services within 30 days of release. This is to ensure a continuity of care and maintenance of therapies currently taken while in correctional facilities. The DOC provides inmates a 30-day supply of medications upon release. Efforts are on going to assess the impact of this discharge system in successfully linking released inmates to care and supportive services. Many inmates do not keep appointments due to substance use recidivism or struggles for basic needs such as food/housing.

These activities will continue during 2004. No new activities are planned.

### **Hepatitis prevention programs**

DHEC's viral hepatitis coordinator is in the Bureau of Disease Control, the same Bureau as the STD/HIV Division which allows for close collaboration. Viral hepatitis services are also integrated with STD/HIV services at the local health department level. Approximately two-thirds of the 70 clinic sites offer Hepatitis A and B vaccines to at-risk STD, HIV and Family Planning clients.

Hepatitis C screening is occurring in seven districts. Staff monitored positivity rates of the persons screened and have recently revised screening criteria to be more targeted to highest risk groups and to expand screening to all districts. Preliminary discussions with district staff occurred and they were receptive to implement screening for all newly diagnosed HIV positive clients, injecting drug users, persons with hemophilia, persons born to HCV-infected women,

and persons with 50 or more lifetime sex partners. Hepatitis C screening is supported through CDC Epi and Lab capacity grant funds and through an HIV services contract from the SC Department of Alcohol and Other Drug Abuse (DAODAS). This contract funds Hepatitis C training to public health and local alcohol and other drug commission staff.

## **TB**

As mentioned previously, the STD/HIV Division and the TB Control Division are both in the Bureau of Disease Control allowing for routine communication and coordination of integrated services. All new TB cases are routinely counseled and encouraged to be tested for HIV infection. Treatment for TB when individuals are co-infected is according to national guidelines. TB staff provide home visits for clients with TB-HIV coinfections to provide direct observed therapy, provide supportive services and referrals as appropriate. Persons requesting HIV testing and counseling services are routinely screened for syphilis, and all HIV infected clients receive PPD skin tests. Case management of co-infected clients and treatment plans often involve joint program staff, especially for complex cases. These activities will continue in 2004.

## **Family Planning and Women's Health Services**

Strong collaboration exists with the STD/HIV Division and health department staff in Family Planning and Women's and Children's Services. Many local health department nursing staff provide integrated family planning/STD/HIV services. The Division provides a clinical training course for new family planning and STD/HIV nurses that includes family planning, STD and HIV clinical components. One health department (Richland County) receives funding through the Office of Population Affairs to routinely screen all Family Planning clients for HIV with an emphasis on reaching more Latinos. Program staff at the state level participate in joint operational planning for clinical services, quality assurance visits, joint program policies, e.g. N-9 policy for condoms and contraceptives), etc. These coordination efforts will continue in 2004.

## **State and Local Education Agencies**

The State Department of Education (SDE) HIV/AIDS Program Coordinator, Aaron Bryan, began serving as a member of the SC HIV Prevention Community Planning Group (CPG) in 2003, providing a link between school health and HIV prevention initiatives. An SDE HIV Program Coordinator has been serving on the CPG since the group was initiated in 1994.

An STD/HIV Division Health Education consultant serves on the SDE materials review committee and the SDE HIV curriculum panel, which meets quarterly.

Discussion have also occurred between DHEC and SDE about reinstituting the training program to develop a "cadre" of trainers in HIV prevention. A local health educator in the Upper Savannah Health District has already worked with SDE to conduct an HIV teacher training in the USHD.

These activities will continue during 2004; no new activities are planned.

## **8. Laboratory Support**

The DHEC Bureau of Labs provides all HIV testing (EIA, Western Blot, CD4, viral load) and referred tests for STDs. CDC HIV prevention funds assist in supporting the annual costs of HIV testing, which is approximately \$400,000. Bureau of Laboratory staff (including the CLIA/Quality Assurance staff) are actively involved in planning and developing protocols for conducting rapid testing and will be involved with training district staff on use of OraQuick.

Additionally, STD/HIV Division, Surveillance and Bureau of Labs staff are currently actively developing plans to conduct incidence and resistance surveillance in early 2004. This will be supported by surveillance funds.

## **9. Other Activities**

As reflected in the budget narrative and justification, the STD/HIV Division has budgeted out of state travel funds to support at least 3 persons to attend at least 3 CDC sponsored 3-day conferences/meetings.

## **10. Summarize Unmet Needs**

Some aspects of the CDC's new HIV prevention initiatives will create challenges for the current program staff in South Carolina. Specifically, the focus on integrating HIV screening in primary care services will require more staff and time with the expertise to work with providers on this strategy. Funding for screening will be a significant barrier raised by providers.

Implementing rapid testing on a wide spread basis is expected to be cost-prohibitive based on the current pricing of testing (about twice as expensive as current EIA costs via serum/oral fluid). This may be minimized in 2004 with free kits provided by CDC and limiting testing to specific settings/populations, e.g. voluntary HIV testing services vs routine screening in STD clinics.

There is a need for increased resources to provide interventions, such as prevention case management or multi-session counseling for HIV infected individuals. This need is based on needs assessments conducted by Ryan White Care providers and also supplemental surveillance surveys during FY 1998 – 2001 with HIV infected individuals indicating that there is a high level of reported unprotected sexual activity among many HIV infected individuals. In order to provide these services, additional funding will be required.

## **11. Management and Staffing Plan**

The SC Department of Health and Environmental Control (DHEC) is the state agency responsible for managing and administering the CDC HIV prevention cooperative agreement. The programs and services are administered by staff in the Bureau of Disease Control, Division of STD/HIV. In addition to implementing the components of a comprehensive HIV prevention program, the STD/HIV Division is responsible for managing STD/HIV prevention services to clients in county health departments, including STD diagnosis and treatment and HIV counseling

and testing services. The STD/HIV Division also administers the Ryan White Care Act Title II and Title IV programs, and the Housing Opportunities for Persons With AIDS (HOPWA).

Key staff involved with managing/administering HIV prevention programs include:

- Lynda Kettinger, STD/HIV Division Director
- Dorothy Waln, Community HIV Prevention Services Manager
- Stan Wardlaw, Prevention Counseling/Prevention Case Management Consultant
- Constance Perkins, HIV Counseling and Testing Consultant/STD Program Liaison
- Sylvia Flint, HIV Prevention Community Planning
- Tony Price and Edena Meetze, Health Education/Risk Reduction Consultants
- Doug Taylor, Program Evaluation Consultant
- James Harris, Training Coordinator and Federal Materials Review Panel Coordinator
- Bill Leverette and Mike Arvelo, Partner Counseling and Referral Services Consultants
- Jim Testor, Communications and Public Information Specialist

In addition, Roshan McDaniel is funded with CDC HIV Surveillance – Capacity Building funds to develop consolidated prevention and care Epidemiologic Profiles and provides assistance with the HIV prevention process/outcome evaluation system.

In varying levels, all above staff are responsible for providing capacity building, evaluation and quality assurance activities for state and local health department providers and through CBO's/contractors. All staff work closely with STD prevention, HIV Surveillance staff and HIV Care and Supportive Services staff to ensure coordination and linkages between prevention and care services. Attachment 7 includes an organizational chart of the Division and a descriptive chart reflecting key functions and other DHEC units that are close partners in implementing HIV prevention services.

Fiscal responsibilities are implemented primarily by DHEC's Health Services Administration unit. This includes managing contracts, disbursing funds, monitoring budgets, etc. The key staff involved with budgeting is Nancy Steele and Joan Carter manages contracts.

Contract monitoring is performed by John Middlebrook, an hourly position funded jointly with HIV prevention and Ryan White Title II funds. This position is organizationally placed in DHEC's Office of Internal Audits but daily work is performed with STD/HIV Division and Health Services Administration staff to provide routine visits to contractors and review fiscal management and accounting practices, monitor invoices and back up documentation, and provide education and technical assistance to contractors to ensure OMB auditing principals are implemented.

The STD/HIV Program uses various tools in monitoring the management of CDC HIV Prevention funds. Representatives from each collaboration/contract site are required to attend quarterly

meetings, provide quarterly and annual reports. Providers are required to present brief reports on activities during quarterly meetings, and the agendas for these meetings deal with ongoing policy issues, training needs and other technical assistance needs. As mentioned previously, Division consultant staff conduct at least one on-site monitoring visit per year to review progress and provide technical assistance as needed. Contract expenditures are monitored on an ongoing basis to ensure that funds are being expended in a timely manner. Contractors have local autonomy in developing their budgets, but they must follow DHEC guidelines and submit budgets to the STD/HIV Program for approval. If contractors are in non-compliance with programmatic and/or fiscal reporting, the state has the option to suspend funding until the contractor meets reporting requirements. Program and fiscal monitoring would be followed by appropriate technical assistance, if needed. An agency wide committee developed contract monitoring policies and standards. Fiscal monitoring/review is being performed on at least an annual basis. More frequent review occurs if an agency is designated high-risk. High-risk designation would be triggered if for instance, an agency consistently submits reports late or with questionable data, if an OMB audit is delinquent, or other non-compliance issues occur.

## **12. Other Requirements**

### **HIV Content Review Guidelines**

The South Carolina HIV Federal Materials Review (FMR) Panel Members List and “Report of Approval” listing approved materials is in Attachment 8. By agency policy, all education materials must be reviewed by an internal DHEC materials review committee comprised of state health department staff. Some materials may be forwarded to the Office of Commissioner staff for final approval. For HIV materials, this review is done once the FMR approves materials. The Report of Approval form for South Carolina reflects the materials that have been reviewed and approved by both processes.

The STD/HIV Division’s web page contains the following notice:

“This site contains HIV prevention messages that may not be appropriate for all audiences. Since HIV infection is spread primarily through sexual practices or by sharing needles, prevention messages and programs may address these topics. If you are not seeking such information or may be offended by such materials, please exit this website.”

Finally, the STD/HIV Division acknowledges and adheres to CDC’s policies for obtaining prior approval for any conferences sponsored with CDC HIV prevention funding. Agendas will be sent to the Grants Management Office as well as the project officer.